MDR: M4-02-2954-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective September 1, 1993 and Commission Rule 133.305 Titled (Request for Medical Dispute Resolution), a dispute resolution review was conducted by the Medical Review Division regarding a medical payment dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement in the amount of $28,818.81 for dates of service 08/23/00 through 08/30/00.

   b. The request was received on 03/21/01.

II. EXHIBITS

1. Requestor:

   a. TWCC 60a/b and Letter Requesting Dispute Resolution dated 05/16/01
   b. UB-92
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted with the original dispute packet was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent:

   a. TWCC 60a/b and Response to a Request for Dispute Resolution dated 05/16/02
   b. HCFA-1500(s)
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted with the original response was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Based on Commission Rule 133.305 (h), the Division notified the insurance carrier Austin Representative of their copy of the request on 05/09/02. The response from the insurance carrier was received in the Division on 05/20/02. Therefore, the insurance carrier's response is timely.

4. Notice of Medical Dispute Resolution is contained in Exhibit 3.
5. The Carrier brought up the issue of the Provider being passed the one year time frame according to TWCC Rule 133.307 (d)(1). However, the Provider submitted evidence of being

compliant with the copies of "Certified Mail" receipts dated 03/20/01 and 04/11/01. Therefore, it has been determined that the Provider is within the one year time frame according to Rule 133.307(d)(1).

III. PARTIES' POSITIONS

1. Requestor:

   a. … " A claim for charges incurred was submitted to (Carrier) in the amount of $83,530.23. A payment in the amount of $6652.10 was received from (Carrier). Submitted an appeal for Reconsideration to the (Carrier). The claim should have been reimbursed at 75% of total charges at Stop-Loss Threshold Rule 134.401. An additional payment in the amount of $26,406.76 was received from (Carrier). The carrier still has not paid accordingly."

2. Respondent:

   a. "According to TWCC Rule 133.307 (d)(1) a request for medical dispute resolution shall be considered timely if it is filed with the carrier and the division no later than one (1) year after the date(s) of service in dispute. These dates of service in dispute are over one year from the dates of service.

      Per 134.401(c)(6)(A)(v), deducted items include personal and non-related items. Personal patient convenience is all listed under the revenue code of 990. The non-related items deducted included items such as Nicoderm and multivitamins. Global services are items such as monitoring, preparation, recovery of general anesthesia, grounding, polarization, oximetry, draping, cautery, suction and airway setup.

The original billed amount:	$83,530.23
Minus the Total Deductions:	$48,509.75
Equals Audited Charges:	$35,020.48

      Again, the Audited Charges, $35,020.48, are below the minimum stop loss threshold of $40,000.00. As such, reimbursement was made at the standard per diem amount for inpatient surgical services at $1,118.00 times 7 days admission equals $7,826.00 minus 15% for the negotiated PPO contact with (third party Carrier) $1,173.90 equals $6,652.10. Plus implantables, which was paid per manufactures invoice plus 10%."

IV. FINDINGS

1. Based on Commission Rule 133.305(d)(2), the only dates of service eligible for review are those commencing on 08/23/00 and extending through 08/30/00.

2. The Provider billed the Carrier $83,530.23 for the dates of service 08/23/01 and extending through 08/30/01.

3. The Carrier made a total reimbursement of $33,058.86 for the dates of service 08/23/01 and extending through 08/30/01.

4. The amount left in dispute is $28,818.51 for the dates of service 08/23/01 and extending through 08/30/01.

5. Phone call was placed to the Provider on 08/28/02 to ask if there is a PPO contract with the Carrier. There was no returned phone call.

6. Carrier indicates in their position statement of a PPO contract with the Provider. However, there is no hard copy of a PPO contract.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $47,871.86. Per Rule 134.401 (c)(6)(A)(i-v), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier deducted $26,406.76 for supply/implants. The Carrier denied "Hospital Services" as and the implantables with the denial code of "O- REIMBURSED @ 1118.00 PER DIEM X 7 = $7826.00- NEGOTIATED PPO CONTRACT =$6652.10 PLUS IMPLANTS PER INVOICE @ 10% = $26,406.76; COMPLETE & FINAL DUE = $33,58.86[SIC]; AFTER CAREFUL RE-REVIEW, WE FIND NO ADDITIONAL PAYMENT DUE." In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem

reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The hospital has billed its "usual and customary charge" of $40,537.50 for the implantables. The carrier has not submitted evidence of what is usual and customary in that region for these items.

Neither the Provider or the Carrier submitted a copy of a PPO contract in their dispute packets.

Therefore, the total reimbursement will be calculated in the following manner:

Total charges are $83,530.23- minus-Pt. convenience and non-related items for a total of $930.50= $82,599.73
Multiply the audited charges of $82,599.73 x 75%
$82,599.73 x .75= $61,949.80
The carrier paid $33,058.86
$61,949.80 - $33,058.86 = $28,890.94
Therefore, additional reimbursement is recommended in the amount of $28,890.94.

The above Findings and Decision are hereby issued this 29th day of August, 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

VI. ORDER

Pursuant to Sections 402.042,413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent, to remit $28,890.94 plus all accrued interest due at the time of payment to the Requestor, within 20 days receipt of this order.

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This Order is hereby issued this 29th day of August 2002.

Judy Bruce
Director of Medical Review
Medical Review Division

JB/mb

This document is signed under the authority delegated to me by Richard F. Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code § 148.3). This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code § 102.5 (d). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P. O. Box 40669, Austin, Texas, 78704-0012. A copy of this Decision should be attached to the request. **Per Rule 133.305 (p) (2), The party appealing the Division's decision shall deliver a copy of its written request for a hearing to all parties involved in the dispute.**

I hereby verify that a copy of this Findings and Decision was placed in the insurance carrier representative's box and mailed to the requestor and claimant applicable to Commission Rule 102.5 this 29th day of August 2002. Per Commission Rule 102.5(d), the date received is deemed to be 5 days from the date mailed.

Signature of Commission Employee: _____

Printed Name of Commission Employee: Pat DeVries